Temali: Jurnal Pembangunan Sosial
eISSN: 2615-5028, Vol 4, No 2, 2021, pp 91-102
https://dx.doi.org/10.15575/jt.v4i2.12824

Procedures for Social Volunteers in Rehabilitating Patients with Mental Disorders In A Rural Community of Bandung

Rifki Rosyad
UIN Sunan Gunung Djati Bandung
rifkirosyad@uinsgd.ac.id

Naan Naan
UIN Sunan Gunung Djati Bandung
naan@uinsgd.ac.id

Busro Busro
UIN Sunan Gunung Djati Bandung
busro@uinsgd.ac.id

Suggested Citation:

Rosyad, Rifki; Naan, Naan; Busro, Busro. (2021). Procedures for Social Volunteers in Rehabilitating Patients with Mental Disorders in A Rural Community of Bandung. *Temali: Jurnal Pembangunan Sosial*, Volume 4, Nomor 2: pp 91-102. https://dx.doi.org/10.15575/jt.v4i2.12824

Article's History:
Received June 2021; *Revised* September 2021; *Accepted* September 2021.
2021. journal.uinsgd.ac.id ©. All rights reserved.

Abstract:
This study aims to explore the efforts made by the family, community, and government in coping with different cases of community mental disorders. Using semi-structured interviews and observations, data was obtained from 25 respondents. The causes of mental health disorders are primarily due to psychosocial or external factors. With medical treatment, patients can escape from their shackles and start socializing with the community. Social communication is one of the most effective ways to treat patients to recognize themselves, reconnect with others, and become mentally healthier. What mainly drives social rehabilitation for people with mental disorders is volunteers who help launch various rehabilitation activities. The study findings can provide valuable information to help enhance public health services, particularly for volunteers, especially in rural communities. This research will directly motivate the government to improve success in overcoming mental disorder-related social problems.

Keywords: mental health disorders; traditional medicine; social approach; Sociology of the family; communication network

Abstrak:
Penelitian ini bertujuan untuk mengeksplorasi upaya yang dilakukan oleh keluarga, masyarakat, dan pemerintah dalam mengatasi berbagai kasus gangguan jiwa masyarakat. Dengan menggunakan wawancara dan observasi semi terstruktur, data diperoleh dari 25 responden. Penyebab gangguan kesehatan jiwa terutama disebabkan oleh faktor psikososial atau eksternal. Dengan perawatan medis, pasien bisa lepas dari belenggu dan mulai bersosialisasi dengan masyarakat. Komunikasi sosial adalah salah satu cara yang paling efektif untuk merawat pasien untuk mengenali diri mereka sendiri, berhubungan kembali dengan orang lain, dan menjadi lebih sehat secara mental. Yang menjadi penggerak utama rehabilitasi sosial bagi penderita gangguan jiwa adalah para relawan yang membantu melancarkan berbagai kegiatan rehabilitasi. Temuan penelitian ini dapat memberikan informasi yang berharga untuk membantu meningkatkan pelayanan kesehatan masyarakat, khususnya bagi relawan, terutama di masyarakat pedesaan. Penelitian ini secara langsung akan memotivasi pemerintah untuk meningkatkan keberhasilan dalam mengatasi masalah sosial terkait gangguan jiwa.

Kata kunci: gangguan kesehatan jiwa; obat tradisional; pendekatan sosial; Sosiologi keluarga; jaringan komunikasi

INTRODUCTION

Humans' problems in the era of the industrial revolution 4.0 are increasingly complex because it has fundamentally changed the way humans think, live, and relate to one another (Shwab, 2016). This era has disrupted various human activity patterns in multiple fields, including technology, economy, society, politics, or ecology (Rahman, 2011). The problems humans face in this era impact physical health conditions and affect a person's mental health conditions due to the various pressures. The World Health Organization (WHO), in recent years, has been highlighting mental health problems that afflict humans in different parts of the world. The world's population with mental health disorders is 35 million people experiencing depression, 60 million people experiencing bipolar disorder, 21 million people experiencing schizophrenia, and 47.5 million people experiencing dementia (World Health Organization, 2019). However, low and middle-income countries allocate less than 2% of their funds to treat and prevent mental disorders (World Health Organization, 2013).

In Indonesia, mental health problems are currently a hot issue that is being discussed a lot. According to primary health research data in 2018, around 7% of Indonesia's population suffers from schizophrenia, 14% have experienced shackling. The Indonesian government's efforts in dealing with mental health problems with the issuance of Law Number 18 of 2018 concerning mental health that there are efforts made include promotive, preventive, curative and rehabilitative. In West Java, according to primary health research data in 2018, the prevalence of schizophrenia mental disorders was 5%; in 2017, the data collected by the West Java health office was 11,360 people. While in 2018, it increased to 16,714 people (Ministry of Health, 2018). The effort of the West Java provincial government to overcome mental health problems is the existence of a Regional Regulation or after this referred to as Local Government Regulation number 5 of 2018 concerning the implementation of mental health; in this regional regulation, the efforts of West Java provincial government to deal with mental health problems besides the Cisarua Mental Hospital, General Hospital types A, B, or C also provide special services for psychiatric problems. Apart from hospitals, community health centers spread throughout West Java facilitate the public to report, detect early, and refer to possible psychological issues.

Mental health problems in West Java also occur in one sub-district in Bandung Regency. Bandung Regency is one of the areas with industrial activities that are not too big and other West Java regions. The tendency of people to try their luck in the industrial sector is very much. Meanwhile, if you look at the livelihoods in general, Bandung Regency people are more likely to work as farmers and farm laborers. These agricultural pockets are located in villages scattered in various sub-districts, including the Banjaran District, the research location, especially in Mekarjaya village [from now on, the Village].

Quiet rural conditions such as the Village are inseparable from mental health problems (Zuldin, 2019). It was recorded that fourteen residents had mental health problems, which the government had just discovered. Here the people of the Village need more services, especially mental health services. Issues regarding mental health problems experienced by some residents require special attention and efforts to overcome them (Millie & Syarif, 2015). This mental disorder's existence is the focus of this research simultaneously with the hope of digging deeper into what actions have been made to overcome this mental health problem, both efforts made routinely by the government or by the volunteers.

To understand more deeply about the implementation of care for mental patients, a straightforward procedure is needed. It is because "procedures" are more precise and more detailed documents to describe the methods used to implement policies and organizational activities as defined in the guidelines. Procedures are written instructions as guidelines for effectively and efficiently completing a routine or repetitive task to avoid variations or deviations affecting overall performance (Soemohadiwidjojo, 2014). Even this procedure can guide anyone who wishes to carry out the social rehabilitation of patients with mental disorders.

LITERATURE REVIEW

Rehabilitation is a process of helping people find a way to return to everyday life before they got sick. With restoration, it is hoped that people with mental disorders can live properly like other people in general. Before discussing further mental health, we must first know the essential thing, namely what is healthy. Healthy can be defined as total wellbeing (a perfect state) physically, mentally, and socially, free from illness or weakness. According to Health Law No.23 of 1992, being healthy is a physical, mental, and social condition which enables every human being to live productively, both socially and economically. According to WHO, mental health is a condition of wellbeing that individuals recognize. There is the ability to manage stress, work

eISSN: 2615-5028, Vol 4, No 2, 2021, pp 91-102
https://dx.doi.org/10.15575/jt.v4i2.12824

productively, and play a role in society. Mental health is the avoidance of individuals from neurosis and psychosis symptoms. Some define mental health as the ability to adapt to oneself, other people, and the society in which they live. An individual is mentally healthy if he can face problems that may be encountered throughout his life.

Mental health science comes from the study of psychology. The efforts of psychologists in giving birth to this new knowledge began with public complaints due to the emergence of disturbing symptoms. Mental health realizes harmony between cognitive functions and self-adjustment between humans and their environment and aims to achieve a meaningful and happy life in this world and the hereafter. Mental health is not only free from mental disorders. Mentally healthy individuals have the following characteristics: (1) Have a right personality attitude towards oneself; (2) Good growth, development, and self-realization; (3) Self-integration, which includes mental balance, unity of view, and resistance to the pressures that occur; (4) Self-autonomy which contains elements of regulating internal behavior or free behavior; (5) Ability to master the environment and integrate well (Dickens et al., 2019).

Other characteristics regarding individuals who are mentally healthy if they have the following features: (1) Feel happy and respect themselves, have indicators of being able to deal with situations, can overcome disappointments in life, are satisfied with their lives, have good self-esteem, and judge himself realistically; (2) Feel comfortable with other people, have indicators of being able to love others, have proper personal relationships, can respect other people's different opinions, feel part of a group; (3) Able to fulfill life guidance by setting realistic life goals, being able to make decisions, being able to accept responsibility, being able to design for the future, being able to take new ideas and being satisfied with the work that has been done (Lund et al., 2019).

Mental health is summarized in four patterns of insight, including (1) a symptomatic-oriented pattern of wisdom. A healthy mental state or a healthy mental state is characterized by a person's freedom from the symptoms of specific psychiatric disorders; (2) Adjustment-oriented insight pattern. This pattern holds that one's ability to adapt is the main element of a healthy mental condition. Adaptation is broadly defined, namely actively striving to meet environmental demands without losing self-respect or meeting personal needs without violating others' rights. Passive adjustment in the form of being completely withdrawn or completely compliant with the needs of the environment is a form of self-adjustment that is not healthy, because it will easily be swayed by situations or isolate oneself; (3) The pattern of insight that is oriented towards developing potential, here humans are dignified creatures who have various potentials such as creativity, sense of humor, sense of responsibility, intelligence, freedom of attitude, and others. According to this view, mental health occurs when these potentials can be developed optimally to benefit oneself and the environment. In developing these potentials, it is necessary to consider the prevailing norms and ethnic values adopted. (4) A pattern of religious or spiritual orientation, where faith and fear of God and trying to apply religious guidance in life (Bastaman, 2007).

METHODOLOGY

The research approach used in this research is qualitative or what is often referred to as naturalistic study (Beuving & de Vries, 2020). Qualitative research is carried out on natural objects (Kaae & Traulsen, 2020). Natural things develop naturally or as they are, without being manipulated, and the researchers' presence does not affect the object. The research instrument or tool in qualitative research is the researchers (Akemu & Abdelnour, 2020). Qualitative research models are used in the research process to obtain in-depth data, data that contains meaning (Bergen & Labonté, 2020). Hence, this qualitative research does not emphasize generalizations but instead emphasizes their significance.

This type of descriptive qualitative research is used to describe mental health disorders and the efforts to deal with mental health disorders carried out in Mekarjaya Village of Banjaran District of Bandung Regency of West Java, Indonesia. This research's data sources are people with mental symptoms who can communicate, volunteers who help manage the patients, the patient's family, and the government.

The data collection techniques in this study were observation, interviews, and documentation. Qualitative data analysis is an effort made by working with data, organizing data, sorting it into manageable units (Eakin & Gladstone, 2020). The qualitative analysis method used in this research is descriptive analysis, which attempts to find something in a particular phenomenon (Rodriguez & Storer, 2020).

RESULTS

Problems of Mental Health

Mental health problems are still frightening things in society (Li et al., 2020). Families who have family members with mental health disorders often try to cover up patients' existence from the community because they think this is a disgrace to the family. The humiliation should be covered so that others do not know it (Corrigan & Miller, 2004). Besides, there was no attempt by the family to seek treatment. In the Village, there are fourteen people with mental health disorders who volunteer community social workers have recorded. People with mental health problems in the Village were only found out when a social volunteer census. From the census process, it was found out that there were residents suffering from mental health problems. Four out of fourteen patients experienced shackling when they first discovered it, and for dozens of years, they were shackled for reasons not to endanger others. It was only discovered that the villagers suffer from mental health problems in 2017. One patient was only located in September 2019 when the head of the neighborhood association, where the patient lived, asked volunteers for help to take him to a rehabilitation area.

Of the 14 patients with mental health disorders in the Village, some were successfully traced to their objective condition when they first discovered they were suffering from mental health disorders.

Patient A is a 41-year-old man; when volunteers first found him, he was shackled beside his house for two years. The first time she was shackled because Patient A burned her mother's house, the family decided to shackle her not to endanger other people.

Patient B is a man who is currently 45 years old when the volunteers first discovered that he had been shackled for 13 years around the burial site with a tarp roof just to cover his head. To feed and drink, the family threw it and did not dare to approach it. Patient B is shackled because his behavior often endangers others.

Patient C is a woman who is currently 24 years old; when volunteers first discovered patient C, she had been shackled for 14 years since she was ten years old. Patient C is shackled in a room in his house, because his family is afraid that if he is released there will be people who are not responsible for acting indecently to patient C. Patient C has been treated for medical rehabilitation but was not taken to the hospital; only doctors from the Regional General Hospital and Mental Hospital came to his house and gave medicine, but patient C never drank it because he always refused to take medicine. Patient C was not taken to a rehabilitation place because her father did not get rehabilitation. When the researcher came to the place where patient C was in shackles, patient C was placed in a room with a perforated roof and smelled bad when he came to his room, because patient C started defecating, urinating and menstruating in that place and only cleaned when his older brother was from patient C has time to clean it. When they want to eat, patient C screams for food, patient C does not want to walk like ordinary people, patient C walks by squatting, and it causes her legs to look smaller.

Patient D was a man when volunteers who suffered from D were first found in shackles because they often carried machetes and broke things in the house. The children of patient D decide to lock him in a room.

Patient E is a man. Currently, patient E has no place to live. His mother abandoned patient E because the mother suffering from E trauma was almost hurt by using a machete; her mother moved to another area and let E remain in the Village. Patient E often picks up trash and talks to himself. It cannot be rehabilitated because, according to volunteers, patient E does not have an identity card or family card.

Patient F is a middle-aged woman, and it was only discovered that she suffered from mental health problems on September 6, 2019. According to the husband's narrative, the head of the neighborhood where patient F lived on September 6, 2019, came to the Volunteer house to ask for help because his behavior was increasingly "strange" and its neighbors. Currently, F patient is in the hospital to get medical rehabilitation services.

Patient G is a man around 40 years old. According to informants, patient G has suffered from mental health problems for a long time. However, patient G does not experience shackling because her behavior does not endanger herself or others. Patient G did not want to wear clothes and did want to take a shower. Daily G patients travel around the Village carrying sacks to collect used plastic such as mineral water bottles and others.

Patient H is a woman. He never experienced lockup because, according to the informant, his behavior was still under control and did not endanger others. According to the informant, H's daily life often sweeps his yard and carries water.

Patient I is the male husband of patient F. Patient I experiences mental health problems before his wife, patient F, experiences mental health problems. Patient I was given medical rehabilitation efforts.

Interviews with resource people from volunteer community social workers, as well as with the patient's family, did not get an explicit explanation of what kind of mental health problems suffered by patients in the Village in the

medical diagnosis from the psychiatrist in charge, because not all patients received medical rehabilitation services. The volunteers as the community social workers only mention the classification or type of mental health disorders into two groups, namely moderate and severe, according to Volunteers who are in the moderate category, namely their behavior does not disturb or endanger others and does not damage goods, while those included in the in the category of people with serious mental health disorders, namely the behavior of the patient that disturbs or endangers others and damages property. According to the volunteers, four people were included in the severe category of the fourteen patients, namely patients A, B, C, and D.

Based on the observations of researchers when they met the patient directly from the behavior and symptoms mentioned by the resource person, both volunteers and the patient's family, it could describe that the patients: often talk to themselves, often hear whispers, hallucinations, moody, behave aggressively, and are unable to socialize or withdraw from the social environment.

Social Factors Causing Psychiatric Disorders

Mental health problems do not just happen; trigger factors cause a person to experience mental health problems (Borsboom, 2017). These factors can come from external or the surrounding environment, internal or from within, and biological or a disturbance in the nervous system (Krueger, 2020). The factors that cause mental health problems are primarily external or environmental (Briguglio et al., 2020). The factors causing mental health disorders in Mekarjaya Village of Bandung Regency based on interviews with volunteers, in general, male patients of mental health disorders are caused by studying spiritual knowledge that does not reach or the Sundanese term is called '*ngelmu'* (seeking spiritual knowledge). At the same time, female patients are caused by household problems.

Patient A before experiencing mental health problems was a Koran teacher at a boarding school. In terms of science, especially religious knowledge, patient A has a relatively broad and deep insight, as evidenced by the fact that patient A has studied at a boarding school and mastered several books. Before patient A experienced mental health problems, patient A had to follow '*khuruj*' (outing). Outing here is taking the time to preach, by being carried out from the house to house and from mosque to mosque on foot and led by an emir (religious leader), members of the outing must not leave the mosque without the permission of the emir. During the interview, patient A admitted that he had followed a tour to move from mosque to mosque in several cities. As he was traveling, Patient A had recently married and had a one-month-old son suddenly asked to divorce his wife by Law because patient A did not own property and was only a Koran teacher. His parents-in-law took his wife and child, who was only one month old, and until now, patient A has never met his child. From this incident patient, A began to show symptoms of suffering from mental health problems. Until patient A on one occasion, burned down his mother's house where he also lived. Since the incident, patient A was shackled with his hands and feet chained to fear endangering others.

Before suffering from mental health disorders, Patient B was active in a martial arts community; according to Patient B's confession during an interview, he had joined a martial arts community called "mental association." Also, patient B migrated to work in other cities. Patient B starts from 'deepening spiritual science' while he is not ready to accept this 'knowledge.' Patient B was shackled for thirteen years because he often endangered others.

Patient C, when he was still a child, was a cheerful and active person. Patient C went to school like children in general, but patient C is physically ill at 7. At that time, patient C was bullied by his school friends until he stopped going to school anymore; patient C turned into a gloomy and not cheerful childlike. Patient C does not get support from the family, especially from the figure of his parents. Since then, patients C's behavior has increasingly shown abnormalities, but parents do not realize that the symptoms lead to mental health disorders as soon as possible. At the age of 10, patient C is shackled by the family and placed in a room.

Before experiencing mental health problems, patients with D were 'smart' people to ask people for unseen matters. According to the sources, Patient D got the inheritance of this spiritual knowledge from his father. Still, patient D could not accept this 'knowledge.' His behavior becomes strange, and he often destroys or throws away items in the house. Due to patient D's condition, his children locked him in a room.

Patient E is a male, the initial cause of suffering from mental health disorders is not much different from patient D. Patient E is stuffed with 'knowledge' by his father, admitting that patient E himself was asked to drink chicken blood by his father, because patient E was afraid, he followed what his father ordered. According to the source, when he was small, person with E, a good and obedient child. Because that patient E, who is not ready to accept

this 'knowledge' feels depressed, one day patient E goes berserk and will hurt his mother with a machete; from this incident, the mother of patient E decides to move house and leave patient E alone in the Village without a home. According to the source, her mother did not want to see patients E because she was afraid.

Patient F is a 49-year-old housewife. Initially, F went to Saudi Arabia to become a female worker but never sent money, even though patient F hoped to help the family economy. After her son came home and decided not to become a female worker in Saudi Arabia, her child was married and brought by her husband. After moving, the child no longer visits patient F, and the family plus the husband of patient F often goes to work and returns home only occasionally. Based on information compiled by the Volunteers since then, his behavior has become strange, gloomier; he talks to himself when asked to speak, does not connect, and one-time cooking stones.

Patients with mental health disorders need to be paid more attention to their handling efforts. One of the government's efforts to deal with mental health disorders is the government program on "Indonesia Free from Shackled"; the program has not been fully realized because many are shackled, including in this research location.

Efforts to Manage Mental Health Problems

Of the 14 patients with mental health disorders in the Village, only five received medical rehabilitation services. The other nine patients did not receive medical rehabilitation services because their behavior did not endanger others and could still be controlled by their families.

Patient A has received medical rehabilitation since 2017 until now. After being rehabilitated in the hospital for several months in 2017, patient A is still on outpatient treatment once a month to the sub-district hospital or Community health centers to have his condition checked by a doctor and given medicine.

Patient B and patient A have received medical rehabilitation since 2017, and it is continuing today. After undergoing treatment in the hospital for several months in 2017, patient B is undergoing medical restoration. Once a month, patient B undergoes an examination by a doctor at the health center or hospital and is given medicine.

Patient C received medical rehabilitation in 2017 when a psychiatric doctor from the General Hospital and Cisarua Psychiatric Hospital visited the Village. A doctor gave him medication, but patient C refused to take medication. Until now, patient C is no longer receiving medical rehabilitation, either intensive care at the hospital or outpatient treatment, because her family, especially her father, has not allowed patient C to be rehabilitated.

Patient D has received medical rehabilitation since 2017 while undergoing treatment at the hospital. Until now, patient D is still receiving medical rehabilitation in the form of drug administration or pharmacotherapy.

Patient F just received intensive medical rehabilitation at Soreang General Hospital in September 2019; his condition was depressed. The head of the neighborhood at the residence of patient F immediately asked for help from a social worker volunteer to refer him to the hospital.

Other patients in the Village have yet to receive rehabilitation, apart from not disturbing other people with mental health disorders who do not receive medical rehabilitation, according to the informants because some did not have complete identity cards such as ID and Family Card, even though it is very it is important to get medical rehabilitation services covered by the government. Five people who have received medical rehabilitation services use government facilities and carry a certificate of disability. For example, patient F does not get medical rehabilitation services because he does not have an identity card. In contrast, patient F comes from economically less able to pay for medical expenses.

In addition to medical rehabilitation based on the source's narrative, the local social department volunteers informed that there would be further rehabilitation for patients with mental health disorders, namely vocational rehabilitation. Vocational rehabilitation is a form of service shown for individuals with mental or physical health disorders, which enables individuals to acquire skills, increase resources, and optimize attitudes and expectations as needed (Masterton et al., 2020). Patients with mental health disorders who will receive vocational rehabilitation services must be stable because vocational rehabilitation will be carried out at the government-owned rehabilitation center, Palamarta, in the Sukabumi area for six months. Patients with mental health disorders who have received medical rehabilitation will be given skills training for six months. After being given skills training, capital would be given to run a business in the patient's place of origin. Volunteers with mental health disorders from The Village still need to be monitored whether their condition is stable or not; people with mental health disorders from The Village may not be registered this year if they have not been declared according to a psychiatric doctor stable. Patients with mental health problems in the Village are still being monitored.

Village officials have made efforts through volunteer community social workers to date have only reached the stage of medical rehabilitation. Community social worker volunteers link to the source system needed by people

eISSN: 2615-5028, Vol 4, No 2, 2021, pp 91-102
https://dx.doi.org/10.15575/jt.v4i2.12824

with mental health disorders, namely medical rehabilitation. So far, only five patients have received medical rehabilitation services. Meanwhile, vocational rehabilitation is solely at the planning stage.

The efforts that the Village has made through volunteer social workers to treat people with mental health disorders have had a real impact. Although only five patients out of a total of 14 sufferers, the five patients who had received rehabilitation improved, did not experience shackled, and communication was slowly smooth. The impact of medical rehabilitation efforts on sufferers of mental health disorders is as follows:

After receiving medical rehabilitation, the medical rehabilitation effort is no longer in shackles, no longer aggressive, communication slowly smoothly, and can be spoken to, but adaptation to the environment is still lacking.

After receiving medical rehabilitation, Patient B is no longer shackled. His behavior is no longer aggressive, social interactions are still not possible, but communication improves, but sometimes he still likes to talk to himself. Patient C had medical rehabilitation but is not continued, for there is no improvement at all.

After receiving medical rehabilitation and getting full attention from family, patient D is no longer in shackles. His behavior is no longer aggressive; social interactions are excellent; he can already travel alone and returned to society like ordinary people and work in the garden.

When the researcher collected the data, patient F had just carried out medical rehabilitation. The researcher had not received any data regarding the F patient's changes after receiving medical rehabilitation services.

DISCUSSION

People with Mental Disorders in the Community

There were fourteen people with mental health disorders, three female sufferers, and eleven male sufferers. The average age of people with mental health disorders in the productive age ranges from 25 to 50 years old. Four of them had had a lengthy lockdown. Their families did not immediately refer to the Mental Hospital and even tended to be closed and get medical rehabilitation assistance only when a health volunteer conducts a census. The awareness and knowledge of the community and village officials regarding mental health were still weak. The Village's problem was that the root of mental health problems came from three main issues: society's lack of understanding of mental health disorders. *Second*, society's stigma against individuals with mental health disorders. *Third*, mental health services were not evenly distributed (Henry, 2020). These three things were due to the uneven socialization of the importance of being aware of mental health down to the village level. It had made matters worse and an increase in sufferers of mental health disorders. Likewise, the lack of qualified human resources in this field had resulted in unequal rehabilitation services for people with mental illnesses. As is known, Indonesia, which had a population of 260 million, only had 773 psychiatrists and 451 clinical psychologists. It was not surprising that very few mental health workers in community health centers (Ministry of Health, 2018).

The slow handling of rehabilitation of mental health disorder patients is also caused by the negative stigma of society who considers disgrace, making community have a negative stigma against individuals suffering from mental health disorders tend to avoid and refuse to assist the individuals, this results in difficulties of the healing process (Fielding & Lam, 2019). The negative stigma from society complicates the healing process and aggravates the sufferer. The patient did not immediately receive rehabilitation services in the research location because the Village had not paid much attention to this problem and added to the unequal access to rehabilitation from the family side, who seemed to be covering up. In 2017, sufferers of mental health disorders in the Village received attention (Iqbal, 2019). The negative stigma has also caused some of the sufferers of mental health disorders in the Village to be abandoned by their partners. The support most needed by sufferers is from their families, especially their partners.

The mental health problems suffered in the Village can be classified into moderate and severe groups. An extreme group is characterized by aggressive and destructive behavior, while an intermediate group does not disturb or harm others (Wetterborg et al., 2020). There are three major causes of mental health disorders: biological factors, psychosocial factors, and sociocultural factors (Bullivant et al., 2020). Biological factors are caused by disorders of the brain and autonomic nervous system, causing mental disorders in a person (Evans et al., 2020). Psychosocial factors, namely factors caused by several things such as having experienced trauma in childhood, losing a mother's figure, and experiencing severe stress due to heavy pressure from the environment, make stress resistance decreases (Klemfuss & Olaguez, 2020).

Meanwhile, sociocultural factors are influenced by objective circumstances in society or societal demands, resulting in pressure on individuals and resulting in various forms of disturbance (Monteil et al., 2020). The speed of change in modern times as it is today results in a person receiving excessive pressure and the possibility of a

more significant mental disorder or what is often called future shock. What is experienced by sufferers of mental health disorders in the Village is caused by severe stress due to various pressures. That is, for example, patient A who is depressed because he is forced to separate from his child and wife, patient B because he is required to perform particular abilities that are beyond his ability, patient C due to ridicule her friends and did not get support from his family. Patient D who also had to do various things to gain certain knowledge beyond his ability, as well as patient E who was forced by his father to do certain things beyond his ability, and patient F who was depressed because he felt lost the figure of a child to economic pressure.

The Importance of Social Mental Health Volunteers

Indonesia is a large country with a dense population. Improve public health status, among others, is achieved by organizing public health services. To regulate effective public health services, the Government of Indonesia has issued Minister of Health Regulation Number 741 the Year 2008 concerning Minimum Service Standards for Health. Also, to satisfy the public with their services, the government created a State-Owned Enterprise, namely the Social Security Service Agency. However, its existence, structure, services, and operational methods still need to be socialized. It is where parties interested in public health, either the government health department or the Agency have to deploy a new structure of services. The most significant part of socialization to the community is the service officers. And that is also a burden borne by local implementers of public health policies, namely workers in community health centers and the community itself who volunteer.

Health services in Indonesia are organized in a hierarchical or bottom-up health care system. The first level is the community's health service system, involving community health centers, Integrated Service Post, Village Maternity Post, and village midwives. The government runs community health centers as an extension of the District Health Office by providing essential health services to the community. To serve remote villages that are outside the reach of the Community health centers, a supporting Community health center can be established under the supervision of a health center. The Village Maternity Post is run by nurses and midwives assigned by the government and assisted by village health volunteers.

The Integrated Service Post is the backbone of community participation in health services. The Integrated Service Post was initially introduced as a national program component to provide nutrition services and essential growth monitoring at the community level. The Integrated Service Post is run entirely by volunteers who are trained as health workers. The activity that is managed by the Integrated Service Post is one of the most successful examples of large-scale nutrition projects in Indonesia and has succeeded in providing nutrition services to 10 million children in 1984. The initial role of the Integrated Service Post was later expanded in the mid-1980s to enter community activities related to family planning and provision of essential health services such as immunization and control of diarrheal diseases with the support of health professionals (Oendari & Rohde, 2020). Now the benefits from these volunteers reach the management of mental illness in the community.

The second health care provided by the district is the hospital, that is, those of types C and D, which at least four specialists serve. Referrals from community health centers are needed to access hospital services, except in an emergency. The provincial hospital administers the third health care (types B and C). It is to these health institutions that mental health volunteers report and coordinate.

Service Procedures by Volunteers

When they first learned of a villager suffering from mental health problems, health volunteers could not immediately assist due to various obstacles, such as the absence of a village health center and access to referral sources that were quite far from Mekarjaya Village. It could only be handled medically when a doctor from the nearest sub-district Community health centers asked whether or not there were people with mental health disorders in the Village who experienced shackled. In 2017, access to refer patients to related institutions began to open. Some people with mental health disorders in the Village come from economically underprivileged families (Nurdin, 2018). For medical rehabilitation costs using the Social Security Administering Body, the government health insurance program can also be used for mental rehabilitation. Also, patients are required to have a letter of incapacity to obtain rehabilitation services funded by the government. In this case, the government has made efforts to realize social welfare as stated in the Republic of Indonesia Government Regulation number 39 of 2012. Local governments and village governments need to play an active role in overcoming mental health disorders, especially if there is an act of shackling, because in the regulation of the Minister of Health of the Republic Indonesia Number 54 of 2017 has been regulated

regarding the prevention of shackling for people with mental disorders. In this Ministerial Regulation, the central government and local governments are responsible for preventing shackling for people with mental illnesses comprehensively and sustainably to eliminate shackles (Nurdin et al., 2019).

It is because human rights remain attached to people, including even people with mental disorders. The right to get quality services is regulated in the Republic of Indonesia's Law, number 18 of 2014. In the Law, that is chapter V of the second part on the rights of people with mental disorders, article 70 states, people with mental illnesses have the right to (a) Get mental health services in facilities easily accessible health services; (b) Receive mental health services following mental health service standards; (c) Obtain guarantees for the availability of psychopharmaceutical drugs according to their needs; (d) Give approval for medical action taken against him; (e) Obtain honest and complete information about mental health data including activities and treatments that have been or will be received from health personnel with competence in the field of mental health; (f) Receive protection from any form of neglect, violence, exploitation, and discrimination; (g) Obtain social needs according to the level of mental disorders; (h) Managing his own and surrendered property by himself.

Following are volunteers' procedures to cure mental disorders in rural Bandung: (1) Volunteers receive reports from the head of the neighborhood association or residents or see directly. (2) Volunteers contact the psychiatric doctor at the health center to deal with people with mental disorders. (3) Volunteers visit the patient's residence. (4) Volunteers approach the family to ask the patient's consent for treatment. (5) If the patient's family consent has been obtained, they are immediately taken to the community health centers or hospital if the patient is economically able. (6) If the patient is financially incapable, volunteers help take care of the administration to receive free medical assistance from the government. (7) Volunteers coordinate with the sub-district Community health centers and village authorities to borrow an ambulance and help with transportation costs from the Village. (8) Patients are taken to the hospital or community health centers. (9) A volunteer accompanies a patient to be examined by an expert; if he has to be hospitalized, the patient is hospitalized accompanied by his family or left alone, depending on the doctor's recommendation. If outpatient care is allowed, the patient will be brought back home (10). Volunteers also educate their families regarding the flow to get handlers from doctors and help doctors explain the schedule of drugs that the patient must take. (11) Volunteers visit patients regularly to their homes to monitor the medication and its progress. Before visiting the patient's home, volunteers bring gifts for the family and the patient. (12) Volunteers see patients, greet them warmly, ask about their condition, and always encourage them to recover quickly by being invited to tell stories, encourage their families, and monitor their family conditions. (13) Suppose the patient has to be in control. In that case, a volunteer delivers it by first preparing a vehicle to coordinate with the community health centers to borrow an ambulance, coordinating with village officials to get transportation funds. If the doctor agrees, the patient is not brought, only family representatives or volunteers who take medicine. (14) Volunteers regularly accompany doctors from sub-district Community health centers to visit patients to their homes. (16) Volunteers take part in proposing doctors who have recovered to receive vocational training. (17) Volunteers also regularly visit patients who have recovered.

A Standard Operating Procedure (SOP) or a 'Procedure' as implemented in the community is a more precise and more detailed document to describe the methods used to execute and enforce policies and organizational activities as specified in the guidelines. A procedure is a written instruction as a guide in completing a routine or repetitive task effectively and efficiently to avoid variations or deviations that can affect the company's overall performance (Wall & Lippel, 2020). Standard Operating Procedures are systems in place to facilitate, organize, and organize work. Although health volunteers are not an official institution and have different treatment techniques for patients with mental disorders, SOP is still needed to obtain satisfactory results and minimize errors.

Then, in practice, the volunteers rely more on communication than on medication. The order held in social touch is: (1) The availability of the message and the person who will convey the message. (2) There are efforts to translate the message into a form that can be described (coded). (3) Message sending. (4) The existence of media that will be used to convey messages. (5) The presence of message recipients. (6) There is an effort to translate the message received into a form that is easy to understand (decoded). (7) Suggestions and understanding of the message conveyed (Lock et al., 2020).

Communication and procedures applied to patients with mental disorders can improve these patients' quality of volunteer services. The regular contact with people with a mental health condition in Citapen Village includes all the factors necessary for successful social interaction. Communication factors adopt imitation, suggestion, identification, and sympathy factors (Vedadi & Warkentin, 2020). It is commonplace and straightforward but challenging to do in people with a mental health condition in the community, not in the

asylum, so the communication and help system becomes a community culture (Gervais et al., 2020). However, if all of this is done regularly, it will achieve the expected goals for society and satisfaction for all parties related to people with mental disorders.

CONCLUSION

In a Bandung Village of Mekarjaya, there were 14 people with mental health disorders. The causes of mental health issues were often due to external influences or psychosocial variables. These factors lead to insistent pressure beyond the capacity, causing extreme stress and exacerbating a less mental health-conscious family climate, worsening the symptoms. The attempts made so far in the Village to deal with mental health problems have only accomplished medical recovery efforts by supplying medicines. Just five of the 14 patients received medical recovery care, namely patients A, B, C, D, and F. Family shame factors that still do not understand mental wellbeing's value were hampering handling efforts. Medical rehabilitation costs can now be compensated by medical rehabilitation programs obtained free of charge by government agencies. Other rehabilitation needs to be strengthened, such as social and vocational.

LIMITATION AND STUDY FORWARD

This study is still limited to the study of communication in handling people with mental disorders. Therefore, reviews from other sciences can also enrich studies like this. Likewise, this study is a case study. Comparative studies of various cases to make generalizations are possible for further analysis of this problem's locus.

ACKNOWLEDGEMENTS

We would like to express our gratitude to the residents of Mekarjaya Village of Banjaran of Bandung for their willingness to be the object of our research. In particular, our most profound appreciation goes to parents who have children with mental disorders who serve all of our data needs during our study. Likewise, thanks to the volunteers who have answered our questions while working to help ease the burden on families with people with mental disorders.

REFERENCES

Akemu, O., & Abdelnour, S. (2020). Confronting the digital: Doing ethnography in modern organizational settings. *Organizational Research Methods*, *23*(2), 296–321.

Bastaman, H. D. (2007). *Logoterapi: Psikologi untuk menemukan makna hidup dan meraih hidup bermakna [Logotherapy: Psychology to find meaning in life and achieve meaningful life]*. Raja Grafindo Persada.

Bergen, N., & Labonté, R. (2020). "Everything Is Perfect, and We Have No Problems": Detecting and Limiting Social Desirability Bias in Qualitative Research. *Qualitative Health Research*, *30*(5), 783–792.

Beuving, J., & de Vries, G. (2020). Teaching qualitative research in adverse times. *Learning and Teaching*, *13*(1), 42–66.

Borsboom, D. (2017). A network theory of mental disorders. *World Psychiatry*, *16*(1), 5–13.

Briguglio, M., Vitale, J. A., Galentino, R., Banfi, G., Dina, C. Z., Bona, A., Panzica, G., Porta, M., Dell'Osso, B., & Glick, I. D. (2020). Healthy eating, physical activity, and sleep hygiene (HEPAS) as the winning triad for sustaining physical and mental health in patients at risk for or with neuropsychiatric disorders: considerations for clinical practice. *Neuropsychiatric Disease and Treatment*, *16*, 55.

Bullivant, B., Rhydderch, S., Griffiths, S., Mitchison, D., & Mond, J. M. (2020). Eating disorders "mental health literacy": a scoping review. *Journal of Mental Health*, 1–14.

Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, *13*(6), 537–548.

Dickens, G. L., Lamont, E., Mullen, J., MacArthur, N., & Stirling, F. J. (2019). Mixed-methods evaluation of an educational intervention to change mental health nurses' attitudes to people diagnosed with borderline personality disorder. *Journal of Clinical Nursing*, *28*(13–14), 2613–2623.

Eakin, J. M., & Gladstone, B. (2020). "Value-adding" Analysis: Doing More With Qualitative Data. *International Journal of Qualitative Methods*, *19*, 1609406920949333.

Evans, B. E., Huizink, A. C., Greaves-Lord, K., Tulen, J. H. M., Roelofs, K., & van der Ende, J. (2020). Urbanicity, biological stress system functioning and mental health in adolescents. *PloS One*, *15*(3), e0228659.

Fielding, R., & Lam, W. (2019). Prevention in Psychosomatic Medical Care and Rehabilitation. In *Person Centered Approach to Recovery in Medicine* (pp. 137–161). Springer.

Gervais, S. J., Sáez, G., Riemer, A. R., & Klein, O. (2020). The Social Interaction Model of Objectification: A process model of goal-based objectifying exchanges between men and women. *British Journal of Social Psychology*, *59*(1), 248–283.

Henry, B. F. (2020). Adverse experiences, mental health, and substance use disorders as social determinants of incarceration. *Journal of Community Psychology*, *48*(3), 744–762.

Iqbal, A. M. (2019). Self, Society, and Repression in Babel: A Psychoanalytic Perspective. *Journal of Asian Social Science Research*, *1*(1), 15–25.

Kaae, S., & Traulsen, J. M. (2020). Qualitative methods in pharmacy practice research. In *Pharmacy Practice Research Methods* (pp. 31–54). Springer.

Klemfuss, J. Z., & Olaguez, A. P. (2020). Individual differences in children's suggestibility: An updated review. *Journal of Child Sexual Abuse*, *29*(2), 158–182.

Krueger, J. (2020). Schizophrenia and the scaffolded self. *Topoi*, *39*(3), 597–609.

Li, J., Liang, W., Yuan, B., & Zeng, G. (2020). Internalized Stigmatization, Social Support, and Individual Mental Health Problems in the Public Health Crisis. *International Journal of Environmental Research and Public Health*, *17*(12), 4507.

Lock, I., Wonneberger, A., Verhoeven, P., & Hellsten, I. (2020). Back to the Roots? The Applications of Communication Science Theories in Strategic Communication Research. *International Journal of Strategic Communication*, *14*(1), 1–24.

Lund, K., Argentzell, E., Leufstadius, C., Tjörnstrand, C., & Eklund, M. (2019). Joining, belonging, and re-valuing: A process of meaning-making through group participation in a mental health lifestyle intervention. *Scandinavian Journal of Occupational Therapy*, *26*(1), 55–68.

Masterton, W., Carver, H., Parkes, T., & Park, K. (2020). Greenspace interventions for mental health in clinical and non-clinical populations: What works, for whom, and in what circumstances? *Health & Place*, *64*, 102338.

Millie, J., & Syarif, D. (2015). Islam dan Regionalisme. *Bandung: Kiblat*.

Ministry of Health. (2018). *Hasil Utama Riset Kesehatan Dasar Tahun 2018 [Main Results of Basic Health Research 2018]*. Ministry of Health of the Republic of Indonesia.

Monteil, C., Simmons, P., & Hicks, A. (2020). Post-disaster recovery and sociocultural change: Rethinking social capital development for the new social fabric. *International Journal of Disaster Risk Reduction*, *42*, 101356.

Nurdin, A. A. (2018). *Sosiologi Organisasi*. Universitas Terbuka.

Nurdin, A. A., Jamaludin, A. N., Supriatna, E., & Kustana, K. (2019). The dynamic of religious life: A study of conflict and integration of Ahmadiyah in Garut, Tasikmalaya and Kuningan, West Java. *Komunitas: International Journal of Indonesian Society and Culture*, *11*(1), 63–74.

Oendari, A., & Rohde, J. (2020). Indonesia's Community Health Workers (Kaders). In H. B. Perry (Ed.), *Health for the People: National Community Health Worker Programs from Afghanistan to Zimbabwe*. United States Agency for International Development (USAID).

Rahman, M. T. (2011). *Glosari Teori Sosial*. Ibnu Sina Press.

Rodriguez, M. Y., & Storer, H. (2020). A computational social science perspective on qualitative data exploration: Using topic models for the descriptive analysis of social media data. *Journal of Technology in Human Services*, *38*(1), 54–86.

Shwab, K. (2016). *The Fourth Industrial Revolution*. Crown Business.

Soemohadiwidjojo, A. T. (2014). *Mudah menyusun SOP*. Penebar Plus.

Vedadi, A., & Warkentin, M. (2020). Can Secure Behaviors Be Contagious? A Two-Stage Investigation of the Influence of Herd Behavior on Security Decisions. *Journal of the Association for Information Systems*, *21*(2), 3.

Wall, A., & Lippel, R. (2020). *Knowledge transfer success-How to facilitate effective knowledge transfer to prevent recurring quality issues*. Chalmers University of Technology Gothenburg.

Wetterborg, D., Dehlbom, P., Långström, N., Andersson, G., Fruzzetti, A. E., & Enebrink, P. (2020). Dialectical behavior therapy for men with borderline personality disorder and antisocial behavior: A clinical trial. *Journal of Personality Disorders*, *34*(1), 22–39.

World Health Organization. (2013). *Investing in mental health: evidence for action*. World Health Organization.

World Health Organization. (2019). *Global action plan on physical activity 2018-2030: more active people for a*

healthier world. World Health Organization.

Zuldin, M. (2019). Ketimpangan Sebagai Penyebab Konflik: Kajian atas Teori Sosial Kontemporer. *TEMALI: Jurnal Pembangunan Sosial*, *2*(1), 157–183.

© 2021 by the authors. Submitted for possible open access publication under the terms and conditions of the Creative Commons Attribution (CC BY SA) license (http://creativecommons.org/licenses/by-sa/4.0/).